STATE OF ALABAMA
DEPARTMENT OF INSURANCE
MONTGOMERY, ALABAMA

REPORT OF EXAMINATION

OF

VIVA HEALTH, INC.

Birmingham, Alabama

AS OF

DECEMBER 31, 2004

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STATE OF ALABAMA
COUNTY OF JEFFERSON

Blase Francis Abreo being first duly sworn, upon his oath deposes and says:

THAT he is an examiner appointed by the Commissioner of Insurance for the State of Alabama;

THAT an examination was made of the affairs and financial condition of VIVA HEALTH, INC. for the period of January 1, 2002 through December 31, 2004;

THAT the following 46 pages constitute the report to the Commissioner of Insurance of the State of Alabama; and

THAT the statements, exhibits, and data therein contained are true and correct to the best of his knowledge and belief.

Francis Blase Abreo
Blase Francis Abreo, CFE

Subscribed and sworn to before the undersigned authority this 2nd day of August, 2006.

Vickie D. Davis
(Signature of Notary Public)

Vickie D. Davis Notary Public
(Printed name)

in and for the State of Alabama

My commission expires COMMISSION EXPIRES SEPT. 27, 2008

GOVERNOR
BOB RILEY

STATE OF ALABAMA
DEPARTMENT OF INSURANCE
EXAMINATION DIVISION
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COMMISSIONER

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STATE FIRE MARSHAL
RICHARD MONTGOMERY

GENERAL COUNSEL
REYN NORMAN

RECEIVER
DENISE B. AZAR

PRODUCER LICENSING MANAGER
JIMMY W. GUNN

Birmingham, Alabama
August 2, 2006

Honorable Walter A. Bell
Commissioner of Insurance
State of Alabama
Department of Insurance
Post Office Box 303350
Montgomery, Alabama 36130-3350

Dear Commissioner Bell:

Pursuant to your instructions and in compliance with the statutory requirements of the State of Alabama and the resolutions adopted by the National Association of Insurance Commissioners, a full scope financial and market conduct examination as of December 31, 2004, has been made of

VIVA HEALTH, INC.

at its home office located at 1400 21st Place South, Birmingham, Alabama 35205. The report of examination is submitted herewith.

Where the description "Company" or "VIVA" appears herein, without qualification, it will be understood to indicate **VIVA HEALTH, INC.**

SCOPE OF EXAMINATION

A full scope financial and market conduct examination was authorized pursuant to the instructions of the Alabama Insurance Commissioner and in accordance with the statutory requirements of the *Alabama Insurance Code* for a Health Maintenance Organization and the regulations and bulletins of the State of Alabama Department of Insurance; and in accordance with the applicable guidelines and procedures promulgated by the National Association of Insurance Commissioners (NAIC); and in accordance with generally accepted examination standards.

The Company was last examined for the three-year period ended December 31, 2001. The current examination covers the intervening period from January 1, 2002 through December 31, 2004, and was conducted by examiners from the Alabama Department of Insurance. Where deemed appropriate, transactions subsequent to December 31, 2004, were reviewed.

The examination included a general review of the Company's operations, administrative practices, and compliance with statutes and regulations. Corporate records were inspected. Income and disbursement items for selected periods were tested. Assets were verified and valued and all known liabilities were established or estimated as of December 31, 2004, as shown in the financial statements contained herein. However, the discussion of assets and liabilities contained in this report has been confined to those items which resulted in a change to the financial statements, or which indicated a violation of the *Alabama Insurance Code* and the Insurance Department's rules and regulations or other insurance laws or rules, or which were deemed to require comments and/or recommendations.

A signed certificate of representation was obtained during the course of the examination. In this certificate, management attests to having valid title to all assets and to the nonexistence of unrecorded liabilities as of December 31, 2004. A signed letter of representation was also obtained at the conclusion of the examination whereby management represented that, through the date of this examination report, complete disclosure was made to the examiners regarding asset and liability valuation, the financial position of the Company, and contingent liabilities.

The market conduct phase of the examination consisted of a review of the Company's territory, plan of operation, policy forms and underwriting practices, claims payment practices, advertising and marketing, compliance with agents' licensing requirements and compliance with privacy regulations.

ORGANIZATION AND HISTORY

The Company was organized as a for-profit stock corporation on February 27, 1995, and commenced business on February 8, 1996. The Company was certified as a Health Maintenance Organization (HMO), as defined in ALA. CODE § 27-21A-1(7) (1975).

The Company was originally incorporated as "HMO Inc.," however, its Articles of Incorporation were amended on August 3, 1995, to change the name to current "VIVA Health, Inc."

The Company was formed as a wholly owned subsidiary of Triton Enterprises, LLC (Triton). Triton was formed, simultaneously with the Company, by the University of Alabama at Birmingham (UAB) (75% owner) and JBL & Company (JBL) (25% owner). During 1996, JBL relinquished its ownership in Triton. Subsequently, the name of Triton was changed to Triton Health Systems, LLC; and, it has since been owned 99% by UAB and 1% by the UAB Educational Foundation.

The Company's authorized capital stock has been changed since incorporation, including change in the par value per share. The changes in the capital are listed below:

- At incorporation, the authorized capital of the Company was $100, which consisted of 10,000 shares of common capital stock with par value of $0.01 per share.
- On August 3, 1995, the Company increased its capitalization to $100,000, which consisted of 10,000 shares of common capital stock with par value of $10 per share.

At December 31, 2004, the Company's Annual Statement reflected outstanding capital stock of $100,000, which consisted of 10,000 shares of common capital stock of $10, par value, per share. Gross paid in and contributed surplus consisted of $13,236,995. Capital and surplus amounts were offset by an unassigned funds deficit of $(603,883), resulting in total capital and surplus of $12,733,112 at December 31, 2004. There were no changes in the capital structure of the Company during the examination period.

At December 31, 2004, the Company insured approximately 26,000 commercial members. Additionally, VIVA's Medicare Advantage product provided insurance coverage for approximately 15,000 Medicare recipients. The Company was

approved to sell and began selling a Medicare advantage product as of October 1998.

MANAGEMENT AND CONTROL

Stockholders

At December 31, 2004, Triton Health Systems, LLC was the sole owner of the Company. Triton is owned 99% by University of Alabama at Birmingham and 1% by University of Alabama Educational Foundation, both are not-for-profit entities.

Board of Directors

The *By-Laws* of the Company provided that the business and affairs of the Corporation shall be managed by the Board of Directors. ARTICLE III, Section 2 of the *By-Laws*, states that "The corporation shall have one (1) to five (5) directors, the precise number to be fixed or changed from time to time... "

Directors elected by the shareholders on December 15, 2004, and serving at December 31, 2004, were as follows:

Name and Residence	Principal Occupation
Arthur Bradford Rollow Birmingham, Alabama	President and Chief Executive Officer, VIVA Health, Inc.
Dr. Carol Zimmerman Garrison Birmingham, Alabama	President, UAB
David Hoidal Birmingham, Alabama	CEO, UAB Health Systems
Richard Margison Birmingham, Alabama	Vice President of Financial Affairs & Administration, UAB
Stephen Pickett Birmingham, Alabama	CFO, UAB Health Systems
Robert Regier Rich, M.D Birmingham, Alabama	Senior Vice President & Dean, UAB School of Medicine

Officers

The Officers of the Company serving at December 31, 2004, were as follows:

Officer	Title
David Earl Hoidal	Chairman of the Board
Arthur Bradford Rollow	President
Richard Lee Margison	Secretary/Treasurer
Letitia Eubanks Watkins	Chief Financial Officer and Chief Operation Officer
Henrik Paul Ohldin*	Comptroller
Elizabeth Clayton Yates	VP of Corporate Development
Michael Scott McDuffie*	VP of Sales
William Douglas Cannon	VP of Information Systems
Terry Dane Knight	VP of Network Develop. & Provider Relations

*Resigned in 2005.

The minutes of Shareholders and Board of Directors meetings were reviewed for the period under examination. The Shareholders of the Company appointed the Chairman of the Board, President and the Secretary/Treasurer in its meeting held on December 15, 2004.

ALA. CODE §10-2B-8.40(a)(1994) states:

> "A corporation has the officers described in its by laws or appointed by the board of directors in accordance with the By-laws."

ARTICLE IV, Sections 1 and 2 of the *By-Laws* provided that:

> "The executive officers of the Corporation shall be chosen by the directors and shall be a President, Secretary and Treasurer. The Board of Directors may also choose a Chairman, Vice President and such other officers as it shall deem necessary, and shall have such duties and powers as may be determined by the Directors. Any number of offices may be held by the same person.
>
> The officers of the Corporation to be appointed by the Directors shall be appointed annually at the first meeting of the Directors held after each annual meeting of the shareholders... "

While the Chairman of the Board, President, and the Secretary/Treasurer were appointed by the Company's shareholders, no other officers serving at December 31, 2004 were appointed by the Board of Directors. The Company should comply with its *By-Laws* and appoint the officers of the Company in accordance with the aforementioned statute and *By-Laws*. A similar recommendation was made during the prior two examinations.

Committees

As of December 31, 2004, the Company had the following committees that reported to the Board of Directors:

- Utilization Management/Quality Improvement Committee
- Credentialing Committee
- Pharmacy & Therapeutics Committee
- Compliance Committee

Utilization Management/Quality Improvement Committee (UM/QI)

The UM/QI Committee was created as a standing committee of the Company by the Board of Directors. The Committee is responsible for implementing the UM/QI programs and serving as the coordinating and advisory body. The UM/QI Committee is composed of physicians representing the different kinds of specialties utilized by health plan members. The physicians are appointed for three year terms and memberships are staggered in order to provide continuity of membership.

The following were members of the UM/QI Committee as of December 31, 2004:

UM/QI Committee Members	
Dr. James Bonner	Dr. John Farley
Dr. Emily Boohaker	Dr. John Gleysteen
Dr. Leigh Copeland	Dr. Larry Kilgore
Dr. Andrew Duxbury	Dr. Mark Lejeune
Dr. Kenneth Elmer	Dr. Nathan Smith

Credentialing Committee

The Credentialing Committee was created as a standing committee of the Company by the Board of Directors and as a subcommittee of the UM/QI

Committee. This Committee is responsible for making physician and facility credentialing and recredentialing recommendations to the Board.

The following were members of the Credentialing Committee as of December 31, 2004:

Credentialing Committee Members	
Dr. Emily Boohaker	Dr. John Jebeles
Dr. Lisa Columbia	Dr. Elizabeth Stahl
Dr. Sally Ebaugh	Dr. Rodney Tucker

Pharmacy & Therapeutics Committee (P&T)

The P&T Committee is an advisory group that serves as an advisor and liaison between the health plan and health care providers with regard to drug evaluation, selection, use, and education matters. This Committee is a policy-recommending body for matters related to the therapeutic use of drugs. The Committee's minimum composition consists of three physicians, one pharmacist, one nurse, and an administrator.

The following were members of the P&T Committee as of December 31, 2004:

Pharmacy & Therepeutics Committee Members	
Dr. Emily Boohaker	Michele Polgar
Staci Branham	Dr. Sarah Rahman
Dr. W. Winn Chatham	Mark Todd

Compliance Committee

The Compliance Committee is responsible for creating and updating the annual compliance plan for compliance with state and federal authorities and regulations. This Committee educates the staff on compliance, investigations of compliance concerns, and conducts internal reviews and audits to determine adherence to the Compliance Plan. The members of the Compliance Committee are a cross-section of Company employees with various seniority and responsibility levels.

The following were members of the Compliance Committee as of December 31, 2004:

Compliance Committee Members	
Kathy Belcher	Cheryl Morrison
Susan Evans	Paula Roberts
Teresa Evans	Cindy Ryland-Holmes
Beverly Jones-Marshall	Libba Yates
Heather Moore	

CONFLICT OF INTEREST

A review was conducted of the 2002, 2003, and 2004 disclosures signed by the Company's Directors, Officers, and employees. The Company did not provide the 2004 Conflict of Interest disclosures for Richard Margison and Robert Rich. The Company should obtain and maintain annual disclosures from its directors, officers, and employees in order to comply with *Article V – Annual Statements* of its Conflict of Interest policy, which requires:

> "Each director, officer, member of a committee with board delegated powers, and responsible employee shall complete and sign a conflict of interest disclosure statement ... "

CORPORATE RECORDS

The Company's Articles of Incorporation, related amendments and By-laws were inspected and found to provide for the operation of the Company in accordance with usual corporate practices.

Records of the meetings and actions of the Board of Directors during the examination period were reviewed. The minutes appeared to be complete with regards to recording actions taken on matters before the respective bodies for deliberation and action.

There were two changes made to the Company's Bylaws by a resolution passed at the Company's June 18, 2003 Board of Directors meeting.

HOLDING COMPANY AND AFFILIATE MATTERS

Holding Company Registration

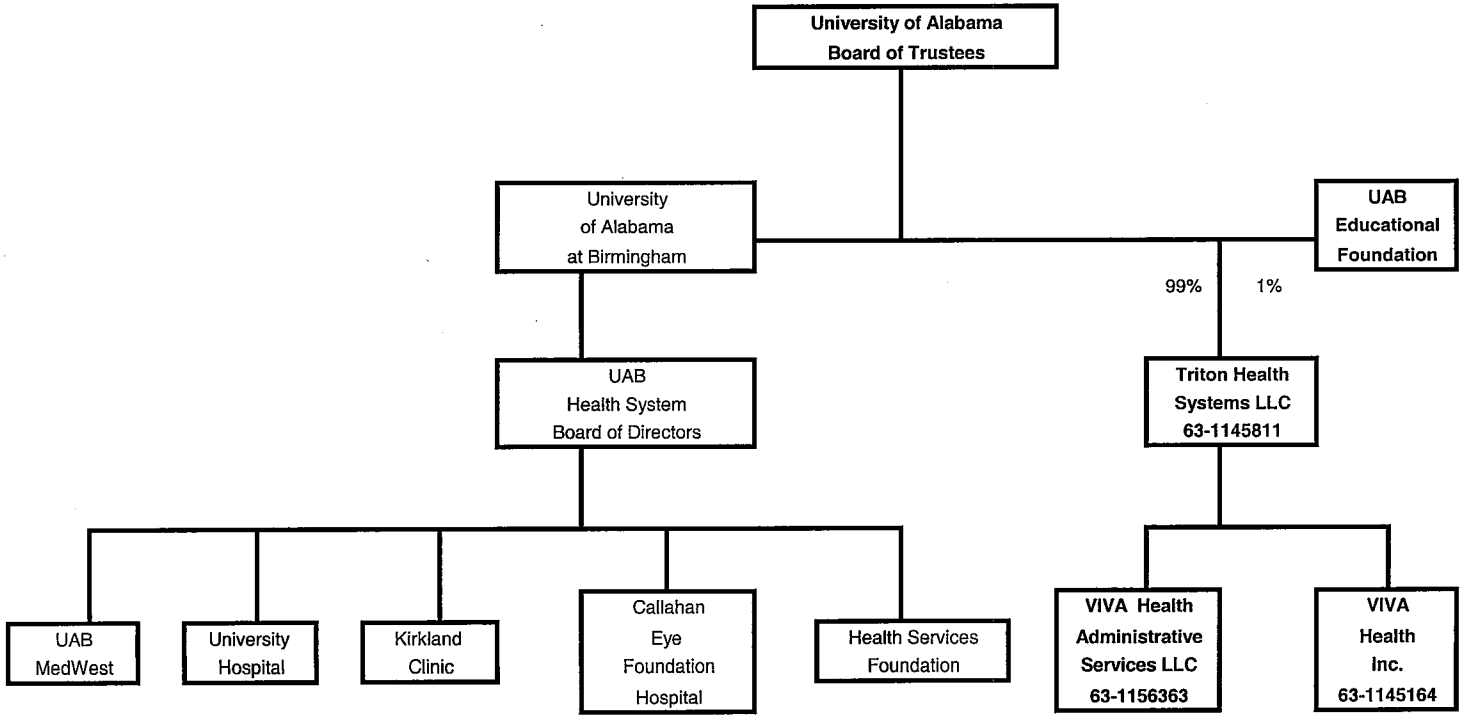
The Company was not subject to the Alabama Insurance Holding Regulatory Act, as defined in ALA. CODE § 27-29-1 (1975), except as expressly required by other statutes and regulations. Generally, HMOs are subject to regulation in regard to changes in control, but are not subject to the continuing holding company reporting requirements that apply to insurance companies.

Dividends To Stockholders

No dividends, to the sole stockholder, were paid during the current examination period.

Organizational Chart

The following chart presents the identities of and interrelationships among all affiliated persons within the Insurance Holding Company System at December 31, 2004:


University of Alabama Board of Trustees
University of Alabama at Birmingham
UAB Educational Foundation
99%
1%
UAB Health System Board of Directors
Triton Health Systems LLC 63-1145811
UAB MedWest
University Hospital
Kirkland Clinic
Callahan Eye Foundation Hospital
Health Services Foundation
VIVA Health Administrative Services LLC 63-1156363
VIVA Health Inc. 63-1145164

Management Services Agreement

The Company operated under a Management Services Agreement with its parent, Triton Health Systems, L.L.C (Triton), which was approved by the Alabama Department of Insurance on July 20, 2001. The agreement was effective June 1, 2001, with a term of one year, which automatically renews annually for an additional one year term, unless terminated by either party with written notice at least thirty days prior to expiration.

In accordance with the terms of the agreement, Triton will perform certain management services and will incur certain monthly expenses on behalf of the Company. The Company will reimburse Triton for all direct expenses incurred by Triton on the Company's behalf. Triton will allocate overhead to the Company for general overhead and administrative costs through assessment of a monthly management fee. The management services to be covered by the monthly management fee include, but are not limited to, general management, personnel management, human resources, facility management, purchasing, accounting, finance, and legal services.

Direct Expenses

All non-healthcare expense, including personnel, that can be clearly identified as exclusively benefiting the Company will be charged to the Company within the accounting records of Triton. The direct charges will include both the charges that relate directly to the Company's commercial business and those related directly to the Company's Medicare (Plus) product. The other expenses that directly benefit the Company or VIVA Health Administration, L.L.C., (VIVA Admin), sister company, will be accumulated and totaled at the end of each month. This amount will then be allocated based on each company's relative membership as a percentage of total monthly membership. Direct expenses anticipated to be paid by Triton on the Company's behalf include, but are not limited to, personnel services, supplies and materials, travel and entertainment, communication services, professional and consulting services, bank charges, advertising, insurance, business licenses, franchise taxes, etc.

Indirect Expenses

Triton expects that the Company will benefit from certain overhead and administrative expenses paid by Triton on the Company's behalf, which are covered by management fee. The management fee for the overhead and administrative costs of Triton will be $19 per member per month, not to

exceed 10% of total premium. The monthly management fees paid by the Company will be expensed between the Company's commercial and Medicare products based on each business line's relative weighted membership as a percentage of total monthly membership.

The agreement cannot be amended, except in writing and signed by both the Chief Executive Officer of the Company and the Manager of Triton. Any amendments or revisions to the agreement will be effective only with the prior written consent of the Commissioner.

A review of the Company's accounts and records indicated that the Company did not pay the management fees in accordance with the terms of the Contract, which states:

> "The management fees for the overhead and administrative cost of Triton will be $19 per member per month, not to exceed 10% of the total premium."

While the Company did not exceed 10% of the premiums, the payments were more than the $19 per member per month. The overpayment of management fees during the period covered by the examination amounted to $18,233,325. A discussion concerning the treatment of the overpayment can be found in the "NOTES TO FINANCIAL STATEMENTS" section of this report under the caption "*Note 3 – Receivable from parent, subsidiaries and affiliates*" on page 32.

A review of Note 10 of the Notes to Financial Statements of the 2004 Annual Statement indicated that management fees, in the amount of $16.4 million were paid to Triton under the Management Service Agreement. The examiner determined that additional expenses in the amount of $8,742,874 were paid to Triton under the Management Service Agreement, which was identified as expenses directly benefiting the Company. The $8,742,874 amount was not disclosed in Notes to Financial Statements.

SSAP No. 25, paragraph 17, NAIC Accounting Practices and Procedures Manual, states:

> "The financial statements shall include disclosures of all material related party transactions. In some cases, aggregation of similar transactions may be appropriate."

FIDELITY BOND AND OTHER INSURANCE

At December 31, 2004, the Company's fidelity bond coverage was included in a crime insurance policy that was issued with Executive Risk Indemnity, Inc. The Company had liability coverage in the following categories: 1) employee theft, 2) premises, 3) in transit, 4) forgery, 5) computer fraud, and 6) funds transfer fraud. The bond provided coverage in accordance with the NAIC guidelines.

In addition to the crime insurance policy, the following policies or coverages were maintained by or on behalf of the Company at December 31, 2004:

- Package Policy
- Automobile Policy
- Umbrella Policy
- Workers' Compensation Policy
- Fiduciary Liability Policy
- Errors and Omissions Policy.

EMPLOYEES' AND AGENTS' WELFARE

The Company had no employees. Its operations were conducted by the personnel of Triton Health Systems LLC, parent company, under the terms of a Management Service Agreement. For further comment, see the caption Management Services Agreement under the heading MANAGEMENT AND CONTROL on page 11.

ALA. ADMIN. CODE 482-1-121 (2003)

The Company did not fully comply with the requirements of ALA. ADMIN. CODE 482-1-121 (2003), which requires that, "Failure to inform the Department of a prior felony conviction on a license application could result in a violation of this statute, as well as constitute grounds for denial of an insurance license. Insurance companies, as well as persons employing anyone to conduct the business of insurance may be in violation of this statute if they willfully permit participation by a prohibited person, including persons who are already employed or being considered for employment. Failure to initiate a screening process in an attempt to identify prohibited persons in current or

prospective employment relationships may be a factor in determining if a violation of this statute has occurred." The Company has a screening process in place for new hires; however, there is no screening mechanism in place for existing employees.

The Company's employment application asks prospective applicants whether they had "ever been convicted of any crime(s) (Felony or Misdemeanor including DUI) other than a routine traffic citation(s)?" If the applicant responded "yes", the Company required that applicants must disclose all offenses on its "Consent for Background Investigation" form. The Company also included in its employment manual that the Company will investigate an applicant's background, "including criminal records from government or private sources as a part of the employment application process. The Company reserves the right to check such records in order to verify the truthfulness of the application and to uncover information which may indicate that a potential employee is untrustworthy or a threat to the company...By accepting continued employment, all current employees acknowledge that this policy applies to them and consent to such background check whenever the Company determines at its discretion that such a check is reasonably necessary. All employees acknowledge that the Company will make such checks at its discretion and will not assume that a check has been made on any co-employee."

The Company also provided evidence that it has established a "Pre-Employment Procedure", which consisted of the Human Resources Department verifying criminal history and verifying that applicants are not listed on the Medicare & Medicaid Sanction-Reinstatement Report. The HR department monitors monthly updates to the "Reinstatement Report" "to ensure that current employees such as: agents, claims staff, and management staff have not been convicted of criminal offenses related to their involvement in Medicare or other social service programs."

SPECIAL DEPOSITS

In order to comply with the statutory requirements for doing business in the state of Alabama, the Company had the following security on deposit with the Alabama Department of Insurance at December 31, 2004:

Description	Par Value	Statement Value	Market Value
First Commercial Bank, CD	$100,000	$100,000	$100,000
Total	$100,000	$100,000	$100,000

MARKET CONDUCT ACTIVITIES

Territory

At December 31, 2004, the Company was licensed to transact business in the state of Alabama. The certificate of authority was inspected for the period under review and found to be in order. The Company was licensed to write its products in the following counties:

Autauga*	Chilton*	Dallas	Madison	Shelby*
Baldwin	Clarke	Elmore*	Marion	St. Clair*
Bibb	Conecuh	Etowah	Mobile	Tuscaloosa
Blount*	Crenshaw*	Jefferson*	Monroe	Washington
Bullock*	Cullman	Lowndes*	Montgomery*	
Calhoun	Dale	Macon	Pike*	

*Medicare licensed counties.

Plan of Operation

The Company's focus has been on conservative, managed growth in commercial large and small groups since its inception in 1996. The Company began its Medicare contract with the Center for Medicare and Medicaid Services (CMS) in October 1998. The Company requires its members to select a Primary Care Physician, as well as a specific hospital network. Medicare Part D became effective January 1, 2006. As a result of this implementation, the Company is expected to increase its growth in membership. The Company is currently licensed in 28 counties across mid-Alabama including the markets of Birmingham and Montgomery.

The Company's agency operations were under the direction of a sales director. As of December 31, 2004, the Company had 98 agents. The Company utilized both independent and captive (in house) agents to market and solicit its business. The independent agents that the Company contracts with are not employed by VIVA Health. The Company's captive agents are on Tritons payroll and only sell VIVA Health products.

Policy Forms and Underwriting Practices

At December 31, 2004, the Company was issuing Commercial Health and Medicare policies. The Company did not file any new policy forms during the four-year period covered by this examination. During the examination period, the Company implemented two rate increases for its health policies for large and small groups based upon the following: factors for age/sex rating, area adjustments, utilization and benefit adjustments, trend and industry. The Company's rate increases were approved by the Alabama Department of Insurance.

In underwriting the Company's health policies for larger groups, the rates were based on claims experience and model rates (age/sex demographics) along with industry and market factors. Rates for large groups are guaranteed for twelve months and are fixed. For small groups, rates are based on the Company's Small Group Rating Model. There are six types of Small Group plans that the Group/Employer can choose from. The Small Group Rating Model utilized age/gender demographics, along with market and group size factors. The rating model for the small groups varies according to health characteristics of the whole group. The Company loads fixed rates into its system based upon tier coverage (single, employee +1, and family). The Company also requested individual's medical records and follow-up health questionnaires for any responses in the application for insurance that were unclear.

The examiners recalculated the policy premiums for a sample of fifty in-force policies that were issued during the examination period. This information was reviewed in order to determine that members were properly charged the applicable rate for policy coverage selected based upon the Group in accordance with the Company's rating plan. Group/Members are rated according to the proposal that VIVA submits and is accepted by the employer or Group. The Company's rating factors are based upon the Group as a whole and each member of the group is rated according to their age, gender, and family status. There were no exceptions noted during this review.

During the review of cancellations, there were six cancellation notices that were not provided out of a sample of 66 records. The examiners were unable to determine whether the member received notification that a policy would be cancelled because the Company was unable to provide evidence that the cancellation notice was sent. To be in accordance with ALA. CODE § 27-21A-16 (f) (1986), the Company is required to comply with the following: "All

records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the commissioner."

Advertising and Marketing

The Company's advertising and marketing strategy focused on the basics of health care and a good image for the Company. The Company utilized both independent and captive (in house) agents to market and solicits its business. The Company's advertising materials included the Company's name and address and identified what policy was being advertised. The advertisements did not misrepresent policy benefits forms or conditions, make unfair or incomplete comparisons with other policies, or make false, deceptive or misleading statements or representations.

During the examination period, communications between the producers and the Company consisted primarily of verbal communication, e-mail, telephone, or fax. The Company primarily uses e-mail to communicate with its agency force; however, the Company could not provide any saved, stored or archived electronic-mail that was broadcast to the sales force. Therefore, the Company is not in compliance with ALA. Code § 27-21A-16(f) (1986), which states, "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the commissioner."

Claim Payment Practices

Claims Paid

The Company's details of claims paid for 2002, 2003 and 2004 were not readily available for review and did not reconcile with the corresponding years annual statements - Underwriting and Investment Exhibit - Part 2. This was also noted in the previous examination. The variances were $143,812, $427,441 and $268,942, respectively. Per the consulting actuary, these variances would not cause a material distortion in the actuarial numbers selected at December 31, 2004.

A sample of eighty claims paid in 2004 and a sample of twenty claims paid in 2005 were selected via ACL. It was determined that the Company could not provide the claim forms for three of the eighty 2004 claims sampled and two of the twenty 2005 claims sampled, which is not in compliance with ALA. Code §

27-21A-16(f) (1986), which states, "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the commissioner."

It was also determined that the Company was not in compliance with ALA. ADMIN. CODE 482-1-118, which states that "Every insurer, which term shall include every domestic insurer, foreign insurer, health maintenance organization, prepaid dental plan, managing general agent or any other legal entity regulated by the Insurance Code and licensed to do business in this state shall maintain its books, records, documents and other business records in order that the insurer's financial condition may be readily ascertained by the Department of Insurance, taking into consideration other record retention requirements. All records must be maintained for not less than five (5) years."

Denied Claims

The examiner selected a sample of 100 denied claims. It was determined that majority of the claims were denied Medicare claims due to the claim already being paid (duplicate claim), which does not require a declination letter. After reviewing the sample of claims, it was determined that twelve of the claims should have had a declination letter sent. It was determined that three of the 12 claims had a declination letter. Four of the twelve claims had a screen print that stated that a letter was generated; however, the Company could not provide a copy of the letter, which is not in compliance with ALA. Code § 27-21A-16(f) (1986), which states,

> "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the commissioner."

A declination letter was not generated for the last five claims because the Company felt that the provider would not bill the member for the amount.

Policyholder Complaints

During the examination period, there were a total of 742 complaints documented in the Company's Complaint Log for: Medicare, Commercial Informal, Commercial Formal, and Commercial Expedited Complaints. The examiners reviewed a sample of 50 complaints. The examiners also reviewed all seven complaints registered with the Alabama Department of Insurance (ALDOI) during the examination period. The examiners reviewed these

complaint files to determine whether the Company maintained appropriate complaints procedures and responded to policyholder issues in a timely manner. From a review of the complaint files, the examiners determined that policyholder's complaints were responded to in a timely manner and the Company's responses properly addressed the issues raised by complainants.

The ALDOI documented seven complaints during the examination period. The examiner reviewed the names of the complainants listed in the ALDOI "complaints report" in order to determine if the Company's complaint logs evidenced the same member names. The examiners did not find where the complainants listed in the ALDOI "complaints report" were also listed in the Company's complaint logs. The Company provided a record of the seven complaints; however, these complaints were not recorded in the Company's complaint log. The Company did not maintain complete and accurate records and record complaints registered with the ALDOI in its complaint log in accordance with ALA. Code § 27-21A-16(f) (1986), which states:

> "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the commissioner."

Compliance with Agents' Licensing Requirements

The examiners reviewed the Company's records to determine that agents representing the Company were duly licensed and appointed by the State of Alabama. The agents listing, consisting of 98 active agents, from the Alabama Department of Insurance Licensing Division was compared with the listing maintained by the Company. No discrepancies were found.

The examiner obtained the policy application files for a sample of fifty in-force policies as of December 31, 2004, which were issued during the years under examination. The examiner reviewed all pages of the application including the signature page for each of the policies in the sample. It was established that the agents were properly licensed and appointed to transact business on behalf of the Company at the time the policies were written.

Compliance with ALA. ADMIN. CODE 482-1-122

The Company does not disclose any nonpublic personal financial or health information to nonaffiliated third parties. The Company detailed in Section 11 of the Privacy/Security Policies and Procedures the steps taken to safeguard

confidential member information, such as: safeguarding conversations, documents, faxes, e-mails, voicemails/messages, computers, and internet communications. However, the Company indicated in its privacy policy that it may disclose the member's medical information for treatment and treatment alternatives, for payment, for health care operations, to individuals involved in the member's care or payment for the member's care, business associates, employers, as required by law, and for certain marketing activities.

The Company appropriately trained its employees, indicated the authorized personnel that have access to personal health information, and established that the Company does have security practices and procedures in place which complied with ALA. ADMIN. CODE 482-1-122.-07 (2001), which states the following: "(6) Confidentiality and security. A licensee describes its policies and practices with respect to protecting the confidentiality and security of nonpublic personal financial information if it does both of the following: (a) Describes in general terms who is authorized to have access to the information. (b) States whether the licensee has security practices and procedures in place to ensure the confidentiality of the information in accordance with the licensee's policy." The Company is also required to comply with ALA. ADMIN. CODE 482-1-126-.08 (2003), which states the following: "(b) Trains staff, as appropriate, to implement the licensee's information security program."

The Company has appropriate policies and procedures in place for the protection against the disclosure of members' nonpublic personal medical information. The Company does not collect or disclose any nonpublic personal financial information. The Company's Privacy Notice content and notice delivery procedures complied with ALA. ADMIN. CODE 482-1-122. The Company also complied with the Health Insurance Portability and Accountability (HIPAA) privacy rule as promulgated by the U.S. Department of Health and Human Services.

FINANCIAL CONDITION/GROWTH OF THE COMPANY

The following schedule presents financial data, which reflects the growth of the Company for the years indicated:

Year	Premium & Related Revenue	Admitted Assets	Liabilities	Capital & Surplus
2001*	$95,775,646	$19,020,223	$17,086,160	$1,934,062
2002	137,958,421	29,132,433	18,711,161	10,060,353
2003	165,011,740	32,321,048	20,923,737	11,397,311
2004*	178,689,650	25,032,290	13,432,971	11,599,319

* Data for the years 2001 and 2004 are per the examination. Data for the remaining years was obtained from the Company's Annual Statements.

REINSURANCE

Reinsurance Assumed

The Company did not assume any business as reinsurance for the three-year examination period; and no contracts for assumed reinsurance were in effect at December 31, 2004.

Reinsurance Ceded

The Company's ceded reinsurance program consisted of a per risk excess of loss treaty with Allianz Life Insurance Company of North America, Minneapolis, Minnesota, and a critical care health care services, transplant, treaty with United Healthcare Insurance Company, Hartford, Connecticut, with United Resource Networks as a program administrator. The agreements were designed to protect the Company from large single risk losses and from losses arising from critical care health care services, "transplant."

Schedule S – Part 3 – Section 2 of the Company's 2004 Annual Statement reported $722,633 in ceded premiums. No reserve credit was taken at year-end 2004 for ceded reinsurance.

The reinsurance contracts in-force as of December 31, 2004 are summarized below:

Allianz Life Insurance Company:

Type of contract:	Per risk excess of loss
Policy effective date:	January 1, 2004, through December 31, 2004. [Contract renewed for a period of one year with changes in the premium rates.]
Lines of Business insured:	1) Commercial; 2) Medicare.
Annual deductible:	$150,000 per member per year.
Maximum reimbursement:	$2,000,000 per member.
Eligible expenses reimbursement:	Covered Acute Care: 90% if paid at a fixed fee. 80% if paid on any other basis. Sub-Acute care: 90% Outpatient care: 90%

United Healthcare Insurance Company:

Type of contract:	Critical care healthcare services "Transplant."
Policy effective date:	October 1, 2004, through October 1, 2005.
Program administrator:	United Resource Networks.
Line of Business insured:	1) Commercial; 2) Medicare.
Maximum life time benefit:	$2,000,000
Maximum reimbursement per covered transplant procedure:	In-Network Services: • 100% of covered charges subject to all applicable limits, terms and conditions of the contract. Travel expenses: • $200 per day • $10,000 maximum total coverage Air Ambulance Services: • $10,000 for air ambulance services Nursing services: • $10,000 for private duty nursing Search and registry fees: • $10,000 Out-of-Network services: • 60% of covered charges. • Other maximum limits apply.

A review of the Company's account and records indicated that the Company had not filed its reinsurance contracts in force during the examination period with the Alabama Department of Insurance in accordance with ALA. CODE § 27-21A-2(e) (1986), which states:

> "An applicant or a health maintenance organization holding a certificate of authority granted hereunder shall file with the commissioner all

contracts of reinsurance. Any agreement between the organization and an insurer shall be subject to the laws of this state regarding reinsurance. All reinsurance agreements and any modifications thereto must be approved by the commissioner."

The NAIC Annual Statement Instructions requires that the *Schedule S - Part 3 - Section 2* list the names of the reinsuring companies. The review of the schedule indicated that the Company did not include United HealthCare Insurance Company, Hartford, Connecticut; one of the two reinsuring companies on *Schedule S - Part 3 - Section 2*. The Company had not appropriately completed the schedule and had not complied with the NAIC Annual Statement Instructions, which states:

"Schedule S - Reinsurance ... Information is included on all reinsurance ceded to other insurance companies authorized as well as unauthorized in the state of domicile of the reporting company."

ALA. ADMIN. CODE 482-1-097-.04(2001), states:

"When submitting required financial reports to the department, all insurers shall use the appropriate NAIC Annual Statement Blank which shall be prepared in accordance with the NAIC Annual Statement Instructions and follow those accounting practices and procedures prescribed by the NAIC Accounting Practices and Procedures Manual, except when in conflict with Alabama statutes or other Alabama Insurance Department Regulations."

ACCOUNTS AND RECORDS

The Company's principal accounting records were maintained on electronic data processing equipment. Management and record-keeping functions were performed by personnel of Triton Health Systems, LLC. under a management and service agreement. Further discussion on the aforesaid agreement is included in this report under the caption HOLDING COMPANY AND AFFILIATE MATTERS under Management Services Agreement in this report.

The Company was audited annually by the independent certified public accounting (CPA) firm of PriceWaterHouseCoopers, Birmingham, Alabama in 2002 and was audited by KPMG, Birmingham, Alabama, in 2003 and 2004.

It was noted that the Company did not maintain complete and accurate records in its home office in accordance with ALA. Code § 27-21A-16(f) (1986), which states, "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the commissioner." The examiners noted exceptions in the following areas during the course of the examination

- Policy Forms and Underwriting Practices – page 16
- Advertising and Marketing – page 17
- Claims Paid – page 17
- Bonds – page 31

In addition, the Company was unable to provide its stock ledger, which is not in accordance with ALA. CODE § 27-21A-16 (f) (1986), which requires: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the commissioner."

Disaster Recovery Plan

The NAIC Information System Questionnaire (ISQ) assists the examiners in determining the strengths and weaknesses within the insurers' IS Department. Company management's responses indicated that there were several weaknesses, including, but not limited to the disaster recovery plan that had never been tested.

- Company management does not periodically validate the access capabilities currently provided to individuals in their department.
- The Company does not have an Information Technology Operations Procedure Manual that is current and enforced.
- The Company does not have a Records Retention Policy for its information systems department. The examiner was told that the policy was being developed and will not be complete until Fall 2006.

Unclaimed property filings

The unclaimed property filing for the year 1998 was submitted in May 2004. Unclaimed property filings are to be filed annually in accordance with ALA. CODE § 35-12-72 (18) 2004, which requires that the Company remit: "All other property, three years after the owner's right to demand the property or

after the obligation to pay or distribute the property arises, whichever first occurs." ALA. CODE § 35-12-76 (f) 2004, also requires: "Before the date for filing the report, the holder of property presumed abandoned may request the Treasurer to extend the time for filing the report. The Treasurer may grant the extension for good cause. The holder, upon receipt of the extension, may make an interim payment on the amount the holder estimates will ultimately be due, which terminates the accrual of penalties on the amount paid."

FINANCIAL STATEMENTS

Financial statements included in this report, which reflect the financial condition of the Company at December 31, 2004, and its operations for the years under examination, consist of the following:

THE NOTES IMMEDIATELY FOLLOWING THE FINANCIAL STATEMENTS IN THIS REPORT ARE AN INTERGRAL PART THEREOF.

VIVA Health, Inc.

STATEMENT OF ASSETS
For the Year Ended December 31, 2004

	Assets	Assets Not Admitted	Net Admitted Assets	Prior Year Net Admitted Assets
ASSETS				
Bonds (Note 1)	$13,701,309		$13,701,309	$ 8,337,848
Cash and short-term investment	8,673,976		8,673,976	21,645,930
Investment income due and accrued	119,213		119,213	144,013
Uncollected premiums and agents' balance in the course of collection	26,008		26,008	19,696
Current federal & foreign income tax recoverable and interest thereon	383,295		383,295	
Net deferred tax asset (Note 2)	331,128	132,128	199,000	1,015,692
Receivables from parent, subsidiaries and affiliates (Note 3)	1,208,372		1,208,372	815,461
Health care & other amounts Receivables	872,916	151,799	721,117	342,408
Total assets	$25,316,217	$283,927	$25,032,290	$32,321,048

THE NOTES IMMEDIATELY FOLLOWING THE FINANCIAL STATEMENTS IN THIS REPORT ARE AN INTERGRAL PART THEREOF.

VIVA Health, Inc.

STATEMENT OF LIABILITIES, CAPITAL AND SURPLUS
For the Year Ended December 31, 2004

	Covered	Uncovered	Total	Prior Year Total
Liabilities:				
Claims unpaid (Note 4)	$8,292,708	$259,568	$8,552,276	$8,102,996
Premiums received in advance	2,920,470		2,920,470	11,604,674
General expenses due or accrued	67,923		67,923	134,140
Current federal and foreign income tax payable and interest thereon				198,960
Amounts due to parent, subsidiaries and affiliates	1,406,004		1,406,004	882,966
Aggregate write-ins for other liabilities (Note 6)	486,298	0	486,298	0
Total Liabilities	$13,173,403	$259,568	$13,432,971	$20,923,737
Capital and Surplus:				
Common Capital Stock			$100,000	$100,000
Gross paid in and contributed surplus			13,236,995	13,236,995
Surplus notes				
Unassigned funds (surplus) (Note 7)	XXX	XXX	(1,737,676)	(1,939,684)
Total capital and surplus	XXX	XXX	$11,599,319	$11,397,311
Total liabilities, capital and surplus	XXX	XXX	$25,032,290	$32,321,048

THE NOTES IMMEDIATELY FOLLOWING THE FINANCIAL STATEMENTS IN THIS REPORT ARE AN INTERGRAL PART THEREOF.

VIVA Health, Inc.

STATEMENT OF REVENUE AND EXPENSES
For the Years Ended December 31, 2004, 2003 and 2002

	Uncovered	2004	2003	2002
MEMBER MONTHS		478,519	495,410	455,896
Net premium income		$178,689,650	$164,994,528	$137,940,801
Aggregate write-ins for other health care related revenues		10,626	17,212	17,620
Total revenues		$178,700,276	$165,011,740	$137,958,421
Medical and Hospital:				
Hospital/medical benefits		$139,613,058	$125,932,980	$96,440,225
Other Professional Services		2,135,232	3,977,147	3,450,829
Emergency room and out-of-area		2,021,190	2,002,473	1,716,231
Prescription drugs		6,709,888	5,688,641	4,300,000
Aggregate Write-ins for other Medical and Hospital		2,270,243	1,661,232	9,787,907
Incentive pool, withhold adjustments and bonus amounts		0	0	96,626
Subtotal		$152,749,611	$139,262,472	$115,791,818
Less:				
Net reinsurance recoveries incurred		$ 6,257	$ 93,425	$ 64,982
Total hospital and medical		$152,743,354	$139,169,048	$115,726,836
Claims adjustment expenses		1,541,590	1,739,330	
General administration expenses		24,186,344	23,207,578	21,495,083
Total underwriting deductions		$178,471,288	$164,115,954	$137,221,919
Net underwriting gain or (loss)		$ 228,988	$ 895,786	736,502
Net investment income earned		531,535	551,627	706,673
Net realized capital gains or (losses)		13,794	4,274	0
Net investment gains or (losses)		$545,329	$ 555,901	$706,673
Net income or (loss)		$774,317	$1,451,687	$1,443,174
Federal and foreign income taxes incurred		$(172,255)	$198,960	$(1,450,219)
Net income (loss)		$ 946,572	$1,252,727	$ 2,893,393

THE NOTES IMMEDIATELY FOLLOWING THE FINANCIAL STATEMENTS IN THIS REPORT ARE AN INTERGRAL PART THEREOF.

VIVA Health, Inc.

STATEMENT OF CHANGES IN CAPITAL AND SURPLUS
For the Years Ended December 31, 2004, 2003 and 2002

	2004	2003	2002
Capital and surplus prior reporting year	$11,397,311	$10,060,353	$7,864,647
GAINS AND LOSSES TO CAPITAL & SURPLUS:			
Net income or (loss)	$ 946,572	$ 1,252,727	$ 2,893,393
Change in net deferred income tax	(684,564)	(389,528)	
Change in nonadmitted assets	$ (60,000)	$ 473,759	$ (697,686)
Net change in capital and surplus	$ 202,008	$1,336,958	$2,195,707
Capital and surplus end of reporting year (rounding)	**$11,599,319**	**$11,397,311**	**$10,060,354**

THE NOTES IMMEDIATELY FOLLOWING THE FINANCIAL STATEMENTS IN THIS REPORT ARE AN INTERGRAL PART THEREOF.

NOTES TO FINANCIAL STATEMENTS

Note 1 – Bonds $13,701,309

The captioned amount is the same as reported in the Company's 2004 Annual Statement.

The examiner determined that the Company did not use either one of the methodologies as described in the NAIC Accounting Practices and Procedures Manual, SSAP No. 43, paragraphs 9-14, to establish prepayment assumption for its loan-backed securities. Loan backed securities are subject to prepayments. The Company should use the prospective or retrospective adjustment methodologies to revalue its loan-backed securities, and make certain the changes in prepayment assumptions are reviewed in accordance with the NAIC Accounting Practices and Procedures Manual, SSAP No.43, paragraphs 9-14.

The examiners determined that thirteen Securities in the Company's portfolio were listed with the "FE" symbol after the "1" designation. PART FIVE, Section 3(e)(ii)(B) Purposes and Procedures Manual of the NAIC Securities Valuation Office, states:

> "A single entry will appear in the VOS publication in its normal CUSIP sequence, followed by the description "All Issues" for the specific securities listed in the U.S. Government Securities Filing Exemption List which is Section 16, 17, and 18 of the Appendix of this Manual...The NAIC Designation for these securities should be NAIC 1."

The aforementioned thirteen securities were determined to be U.S. Government NRSRO Rated Issuer Filing Exemption securities and were listed in Section 17 of Appendix in the Purposes and Procedures Manual of the NAIC Securities Valuation Office. The Company should report the securities that are listed in Section 17 of the Purposes and Procedures Manual of the NAIC Securities Valuation Office without the "FE" symbol after the "1" designation.

Note 2 - Net deferred tax asset $199,000

The captioned amount is $712,723 less than the $911,723 amount reported by the Company in its 2004 Annual Statement.

The accounts and records provided by the Company to support the *Net deferred tax assets* reported at year-end 2004 were reviewed by the examiners. It was established that the deferred tax asset of $911,723 recorded by the Company at December 31, 2004, was computed by the independent CPAs during their audit of the 2003 statutory financial statements. The Company had not independently computed the deferred income tax assets (DTAs) and liabilities (DTLs) based on the expected future tax consequences of temporary differences generated by statutory accounting for the year 2004, which was not in compliance with the guidance provided by SSAP No. 10, paragraphs 5 - 7, of the NAIC Accounting Practices and Procedures Manual, which states:

> "5. A reporting entity's balance sheet shall include deferred income tax assets (DTAs) and liabilities (DTLs), the expected future tax consequences of temporary differences generated by statutory accounting, as defined in paragraph 11 of FAS 109.
>
> 6. A reporting entity's deferred tax assets and liabilities are computed as follows: a. Temporary differences are identified and measured using a "balance sheet" approach whereby statutory and the tax basis balance sheets are compared.
>
> 7. Changes in DTAs and DTLs, including changes attributed to changes in tax rates and changes in tax status, if any, shall be recognized as a separate component of gains and losses in unassigned funds (surplus). DTAs and DTLs shall be offset and presented as a single amount on the statement of financial position."

The CPA's calculation of 2004 net deferred tax assets was computed within the guidelines of SSAP No. 10, of the NAIC Accounting Practices and Procedures Manual. The asset as calculated by the CPAs was $331,128, of which $132,128 was not admitted in accordance with the guidance provided by the aforementioned SSAP. Changes made in this report of examination reduce the admitted assets to $199,000 from $911,723, which reduces the surplus by $712,723.

Note 3 - Receivables from parent, subsidiaries and affiliates **$1,208,372**

The captioned amount is the same as reported in the Company's December 31, 2004 Annual Statement.

The examiners reviewed the Company's accounts and records for the period under examination including the Management Services Agreement and established that the Company had not complied with the terms of the approved Management Services Agreement, which states:

> "The management fees for the overhead and administrative cost of Triton will be $19 per member per month, not to exceed 10% of the total premium."

While the Company did not exceed 10% of premiums, the payments were more than the $19 per member per month.

The following table summarizes the overpayment of management fees:

Year	No of Member months	Management fees per examination	Management fees paid by Company	Difference (overpayment)
2002	455,896	$ 8,662,024	$13,000,000	$ 4,337,976
2003	495,410	9,412,790	16,000,000	6,587,210
2004	478,519	9,091,861	16,400,000	7,308,139
	Total	$27,166,675	$45,400,000	$18,233,325

The examiners proposed to establish a receivable from parent in the amount of $18,233,325 and non-admit said receivable because the amount paid was not in accordance with the approved management contract.

The proposed entry would be to reduce the general administrative expenses reported in the 2004 Statement of Revenue and Expenses. The journal entry resulting from the reclassification would increase the Company's net income; however, since the receivable would not be admitted there would be no effect on the Company's *Total capital and surplus*.

Company management indicated that they were going to record the overpayment of management fees in the 2006 Annual Statement and write-off the same through the 2006 Statement of Revenue and Expenses as uncollectible. The transactions when booked will have no net effect on the Company's capital and surplus and net income.

Note 4 - Claims unpaid and Unpaid claims adjustment expenses $8,552,276

The captioned liability is $100,000 less than the $8,652,276 reported by the Company in its 2004 Annual Statement, but $2,052,581 more than the $6,599,695 determined by this examination.

The following schedule outlines the components of the Claims unpaid and Unpaid claim adjustment expenses liabilities per the Company and our examination:

Claims unpaid and Unpaid claims adjustment expenses	Per Company	Per Examination	Difference
Claims unpaid:			
Commercial & Medicare	$8,200,000	$5,893,585	$(2,306,415)
Pharmacy	352,276	352,276	
Prime Health	100,000	100,000	
Total Claims unpaid	**$8,652,276**	**6,345,861**	**$2,306,415**
Unpaid claims adjustment expenses (UCAE)	0	253,834	253,834
Total Claims unpaid and Unpaid claims adjustment expenses	**$8,652,276**	**$6,599,695**	**$(2,052,581)**

The $100,000 difference noted in the first paragraph above is a reclassification of a guaranty fund assessment which was included in the Claims unpaid liability (Prime Health) that should have been classified as Aggregate write-ins for other liabilities (see Note 6 – Aggregate write-ins for liabilities).

When compared to the actuarial examiner's calculation, the Company's Claims unpaid liability was overstated by $2,306,415, indicating that the Company experienced favorable development on year-end 2004 reserves. The actuarial examiner reviewed the Company opining actuary calculation and determined that the opining actuary had taken a very conservative approach in their reserve estimate. No changes to the *Claims unpaid* reserves were recommended by the actuarial examiner.

SSAP No. 85, paragraph 3, of the NAIC Accounting Practices and Procedures Manual states:

> "Claims Adjustment Expenses for Accident and health Reporting Entities are those costs expected to be incurred in connection with the

adjusting and recording of accident and health claims defined in SSAP No. 55."

The Company did not report any amount under UCAE; however, the actuarial examiner determined that the Company's opining actuary calculated UCAE in the amount of $1,075,998 and included this in the Claims unpaid liability. The actuarial examiner determined that UCAE liabilities are typically calculated between 3% and 5% of Claims Unpaid and utilized 4% in their calculation which amounted to $253,834.

Note 5 - General Expenses Due or Accrued $67,923

The captioned liability is $34,772 more than the $33,151 amount reported by the Company in its 2004 Annual Statement.

The Company had a liability of $34,772 for its premium taxes, for which there was not an accrual set up. The Company should have accrued this amount in accordance SSAP No. 5 paragraph 2 of the NAIC, Accounting Practices and Procedures Manual, which states that:

"A liability is defined as certain or probable future sacrifices of economic benefits arising from present obligations of a particular entity to transfer assets or to provide services to other entities in the future as a result of a past transaction(s) or event(s)."

Note 6 - Aggregate write-ins for other liabilities $486,298

The captioned amount is $486,298 more than the $-0- amount reported by the Company in its 2004 Annual Statement.

The review of the Company's accounts and records indicated that premium refunds for risk sharing agreements for two groups amounted to $268,397 and $117,901. The Company did not estimate the liability as of the examination date as required by the guidance provided by SSAP No. 5, paragraph 2, of the NAIC Accounting Practices and Procedures Manual, which states:

"A liability is defined as certain or probable future sacrifices of economic benefits arising from present obligations of a particular entity to transfer assets or to provide services to other entities in the future as a result of a past transaction(s) or event(s)."

The examination adjustment reduces the Net premium income by $386,298 and the Net income by $386,298, which in turn reduces the unassigned funds (surplus).

As explained in Note 4 of the report, the Company was carrying a reserve in the claims unpaid line item for the potential assessment by the Guaranty Fund for PrimeHealth, which was not in compliance with the NAIC Annual Statement Instructions - Health. The Company should have included the assessment in the aggregate write-ins for other liabilities. As a result, this examination has reclassified the $100,000 reserve for future Guaranty Fund assessments to the appropriate line item.

Note 7 - Unassigned funds (surplus) $(1,737,676)

The unassigned funds (surplus) balance of the Company, as determined by this examination, was $1,133,793 less than the $(603,883) reported by the Company in its 2004 Annual Statement. The following presents a reconciliation of unassigned funds per the Company's filed Annual Statement to that developed by this examination:

Unassigned funds balance per Company			$(603,883)
Examination increase / (decrease) to assets:			
Net deferred tax asset (**Note 2**)	$(712,723)		
Total Decrease to Assets		$(712,723)	
Examination (increase) / decrease to liabilities:			
Claims unpaid (**Note 4**)	$ 100,000		
General expenses due and accrued (**Note 5**)	($34,772)		
Aggregate write-ins for other liabilities (**Note 7**)	(486,298)		
Total Increase to Liabilities		$(421,070)	
Net Increase (Decrease)			$(1,133,793)
Unassigned fund balance per Examination			$(1,737,676)

CONTINGENT LIABILITIES AND PENDING LITIGATION

Examination of these items included the following: a review of the Company's statutory financial statements disclosures; performance of a search for unrecorded items; obtaining letters of representation from management; and, a review of the external auditors summary of pending litigation. There were no material contingencies identified.

COMPLIANCE WITH PREVIOUS RECOMMENDATIONS

A review was conducted during the current examination with regards to the Company's compliance with the recommendations made in the previous examination report. This review indicated that the Company had satisfactorily complied with the prior recommendations, with the exception of the following:

1.) Aggregate write-in for other liabilities - It is recommended that the Company correctly classify its guaranty fund assessment reserve in its future financial filings in accordance with the NAIC Annual Statement Instruction-Health. The Company was carrying a reserve in the claims unpaid line item for the potential assessment by the Guaranty Fund for PrimeHealth; therefore, the Company did not comply with the previous examination recommendation. The Company should have included the assessment in the aggregate write-ins for other liabilities. See the Aggregate write-in for other liabilities note on page 35 for the where this was discussed.

2.) Reinsurance - It is recommended that the company complete Schedule S - Part 3 - Section 2 in accordance with the guidance provided by the NAIC Annual Statement Instructions and ALA. ADMIN. CODE 482-1-097-.04(2001). The Company did not comply with this recommendation. See Reinsurance on page 21 for where this was determined.

3.) Management and Control - It was recommended that the Company maintain copies of signed annual Conflict of Interest statements for all of its directors, officers, and employees in accordance with its conflict of interest policy. It was determined that the Company did not fully comply. See Conflict of Interest on page 8 of this report.

4.) Accounts and Records - It was recommended that the Company maintain complete and accurate records in its home office in accordance with ALA. CODE § 27-21A-16 (f) (1986), which requires, "All records necessary for the

complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the commissioner." The Company did not comply with this recommendation. See Accounts and Records on Page 23 for where this was discussed.

COMMENTS AND RECOMMENDATIONS

Officers - Page 5

It is recommended that the Company keep a permanent record of all actions taken by the board of directors in accordance with ALA. CODE §10-2B.16.01(1994), states:

> "A corporation shall keep as permanent records minutes of all meetings of its shareholders and board of directors, a record of all actions taken by the shareholders or board of directors without a meeting, and a record of all actions taken by a committee of the board of directors in place of the board of directors on behalf of the corporation."

Conflict of Interest - Page 8

It is again recommended that the Company maintain copies of signed annual Conflict of Interest statements for all of its directors, officers, and employees in accordance with its conflict of interest policy. This was also noted during the prior examination.

Management Service Agreements - Page 11

It is recommended that the all material transactions occurring under the Management Services Agreement be reported in Notes to Financial Statements in accordance with the guidance provided by SSAP No. 25, paragraph 17, NAIC Accounting Practices and Procedures Manual, which states:

> "The financial statements shall include disclosures of all material related party transactions. In some cases, aggregation of similar transactions may be appropriate."

ALA. ADMIN. CODE 482-1-121 (2003) – Page 13

It is recommended that the Company institute a screening mechanism to attempt to identify prohibited person(s) as required by ALA. ADMIN. CODE 482-1-121 (2003), which states that: "Failure to inform the Department of a prior felony conviction on a license application could result in a violation of this statute, as well as constitute grounds for denial of an insurance license. Insurance companies, as well as persons employing anyone to conduct the business of insurance may be in violation of this statute if they willfully permit participation by a prohibited person, *including persons who are already employed* or being considered for employment. Failure to initiate a screening process in an attempt to identify prohibited persons in *CURRENT* or prospective employment relationships may be a factor in determining if a violation of this statute has occurred."

Policy Forms and Underwriting Practices – Page 16

It is recommended that the Company maintain complete and accurate records of all cancellation notices in accordance with ALA. CODE § 27-21A-16 (f) (1986), which states: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the commissioner."

Advertising and Marketing – Page 17

It is recommended that the Company develop a policy to maintain, save, archive or store communications with its producers in compliance with ALA. CODE § 27-21A-16 (f) (1986), which requires: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the commissioner."

Claim Payment Practices - Page 17

It is recommended that the Company have all paid claims detail readily available for review and that theses paid amounts, per the detail, reconcile with the reported numbers in its Annual Statements. The Company should maintain complete and accurate records of its claims in accordance with Ala. Code § 27-21A-16(f) (1986), which states, "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the commissioner."

It is recommended that the Company maintain records for at least five years in accordance with ALA. ADMIN. CODE 482-1-118, which states that "Every insurer, which term shall include every domestic insurer, foreign insurer, health maintenance organization, prepaid dental plan, managing general agent or any other legal entity regulated by the Insurance Code and licensed to do business in this state shall maintain its books, records, documents and other business records in order that the insurer's financial condition may be readily ascertained by the Department of Insurance, taking into consideration other record retention requirements. All records must be maintained for not less than five (5) years."

It is recommended that the Company maintain copies of the declination letters sent out. The Company should maintain complete and accurate records of its claims in accordance with ALA. CODE § 27-21A-16 (f) (1986), which requires: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the commissioner."

Policyholder Complaints – Page 18

It is recommended that the Company record all complaints both consumer direct and complaints registered with the ALDOI in its complaint log in accordance with ALA. CODE § 27-21A-16 (f) (1986), which requires: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the commissioner."

Reinsurance – Page 21

It is recommended that the company file all reinsurance agreements for approval, with the Alabama Department of Insurance in accordance with ALA. CODE § 27-21A-2(e), which states:

> "An applicant, or a health maintenance organization holding a certificate of authority granted hereunder shall file with the commissioner all contracts of reinsurance. Any agreement between the organization and an insurer shall be subject to the laws of this state regarding reinsurance. All reinsurance agreements and any modifications thereto must be approved by the commissioner."

It is again recommended that the Company include the name of all reinsuring companies in Schedule S - Part 3 - Section 2 in accordance with the guidance provided by the NAIC Annual Statement Instructions, which states:

> "Schedule S - Reinsurance ... Information is included on all reinsurance ceded to other insurance companies authorized as well as unauthorized in the state of domicile of the reporting company."

ALA. ADMIN. CODE 482-1-097-.04(2001), states:

> "When submitting required financial reports to the department, all insurers shall use the appropriate NAIC Annual Statement Blank which shall be prepared in accordance with the NAIC Annual Statement Instructions... "

Accounts and Records – Page 23

It is again recommended that the Company maintain complete and accurate records in accordance with ALA. CODE § 27-21A-16 (f) (1986), which requires: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the commissioner."

It is recommended that the Company's management periodically validate the access capabilities currently provided to individuals in their departments.

It is recommended that the Company update and test its disaster recovery plan to ensure the effectiveness and strength of its IS Department, implement a current business contingency plan in order to analyze the impact of the Company's business, and address all significant business activities, including financial functions, telecommunication services, data processing and network services.

It is recommended that the Company maintain an Information Technology Operations Procedure Manual that is current and enforced.

It is recommended that the Company maintain a Records Retention Policy for its information systems department.

It is recommended that the Company file its unclaimed property filings annually in accordance with in accordance with ALA. CODE § 35-12-72 (18)

2004, which requires that the Company remit: "All other property, three years after the owner's right to demand the property or after the obligation to pay or distribute the property arises, whichever first occurs." .

It is also recommended that in the event that the Company does have a late filing that the Company "request the Treasurer to extend the time for filing the report" in accordance with ALA. CODE § 35-12-76 (f) 2004.

Bonds - Page 31

It is recommended that the Company revalue its loan-backed securities by using either the prospective or retrospective adjustment methodologies in accordance with the NAIC Accounting Practices and Procedures Manual, SSAP No. 43, paragraphs 9-14.

It is recommended that the Company should report the U.S. Government NRSRO Rated Issuer Filing Exemption securities, which are listed in Section 17 of Appendix in the Purposes and Procedures Manual of the NAIC Securities Valuation Office with out the "FE" symbol after the "1" designation in accordance the guidance provided by PART FIVE, Section 3(e)(ii)(B) Purposes and Procedures Manual of the NAIC Securities Valuation Office, states:

> "A single entry will appear in the VOS publication in its normal CUSIP sequence, followed by the description "All Issues" for the specific securities listed in the U.S. Government Securities Filing Exemption List which is Section 16, 17, and 18 of the Appendix of this Manual...The NAIC Designation for these securities should be NAIC 1."

Net deferred tax asset - Page 31

It is recommended that the Company perform the calculation of deferred income tax assets (DTAs) and liabilities (DTLs), based on the expected future tax consequences of temporary differences in the balance sheet for the reporting year in accordance with the guidance provided by SSAP No. 10, paragraphs 5 - 7, of the NAIC Accounting Practices and Procedures Manual, which states:

> "5. A reporting entity's balance sheet shall include deferred income tax assets (DTAs) and liabilities (DTLs), the expected future tax consequences

of temporary differences generated by statutory accounting, as defined in paragraph 11 of FAS 109.

6. A reporting entity's deferred tax assets and liabilities are computed as follows: a. Temporary differences are identified and measured using a "balance sheet" approach whereby statutory and the tax basis balance sheets are compared.

7. Changes in DTAs and DTLs, including changes attributed to changes in tax rates and changes in tax status, if any, shall be recognized as a separate component of gains and losses in unassigned funds (surplus). DTAs and DTLs shall be offset and presented as a single amount on the statement of financial position."

Receivables from parent, subsidiaries and affiliates – Page 32

It is recommended that the Company pay management fees to Triton Health System, L.L.C. in accordance with the terms of the approved contract, which states:

"The management fees for the overhead and administrative cost of Triton will be $19 per member per month, not to exceed 10% of the total premium."

Claims unpaid - Page 34

It is recommended that the Company establish a separate reserve for Unpaid claims adjustment expenses as required by SSAP No. 85, paragraph 3, of the NAIC Accounting Practices and Procedures Manual states:

"Claims Adjustment Expenses for Accident and health Reporting Entities are those costs expected to be incurred in connection with the adjusting and recording of accident and health claims defined in SSAP No. 55."

It is recommended that the Company continue to review its lag studies and methodologies and utilize those methods that will most closely estimate the Company's Claims unpaid liability.

It is recommended that the Company review the Statement of Statutory Accounting Principles (SSAP) No. 55 and SSAP No. 85 in order to determine those administrative expenses that should be selected in calculating UCAE.

General Expenses Due or Accrued - **Page 35**

It is recommended that set up an accrual for its premium taxes in accordance with SSAP No. 5 paragraph 2 of the NAIC, Accounting Practices and Procedures Manual, which states that:

> "A liability is defined as certain or probable future sacrifices of economic benefits arising from present obligations of a particular entity to transfer assets or to provide services to other entities in the future as a result of a past transaction(s) or event(s)."

Aggregate write-ins for other liabilities – **Page 35**

It is recommended that the Company estimate the liability for premium refunds from the risk sharing agreement between the Company and commercial groups in accordance with the guidance provided by SSAP No. 5, paragraph 2, of the NAIC Accounting Practices and Procedures Manual, which states,

> "A liability is defined as certain or probable future sacrifices of economic benefits arising from present obligations of a particular entity to transfer assets or to provide services to other entities in the future as a result of a past transaction(s) or event(s)."

It is again recommended that the Company correctly classify its guaranty fund assessment reserve in its future financial filings in accordance with the NAIC Annual Statement Instruction-Health.

Subsequent Events – **Page 45**

It is recommended that the Company keep detailed records of its assets that reconcile to its general ledger in accordance with ALA. CODE § 27-21A-16 (f) (1986), which states: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the commissioner."

SUBSEQUENT EVENTS

The 2005 cash receipts and disbursements provided by the Company did not reconcile to the general ledger. The difference between the dataset and the examiners reconciliation was $510,903.

The 2006 cash receipts and disbursement for the first quarter did not reconcile to the general ledger. The difference between the dataset and the examiners reconciliation was $12,108.

Company management did not provide the reconciling items; hence the Company was not incompliance with ALA. CODE § 27-21A-16 (f) (1986), which states: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the commissioner."

There were no significant subsequent events noted.

CONCLUSION

Acknowledgement is hereby made of the courtesy and cooperation extended by all persons representing the Company during the course of the examination.

The customary examination procedures, as recommended by the National Association of Insurance Commissioners for health maintenance organizations, have been followed in connection with the verification and valuation of assets and the determination of liabilities set forth in this report.

In addition to the undersigned, Anne Pruett, Juliette Glenn, Whitney Smith, Examiners for the Alabama Department of Insurance, and Joseph J. Wallace, Jr., ASA, MAAA, of the firm, Taylor-Walker & Associates, Inc., representing the Alabama Department of Insurance, participated in this examination.

Respectfully submitted,

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